		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 31245

Facility Name: Marigold Health Care Center

Address: 275 East Carl Sandburg Drive (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: 309-344-1151 **Fax #** 309-344-2007

IDPA ID Number: 51-0271905005

Date of Initial License for Current Owners: 09/12/86

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ken Marx, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2004 to 06/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Junior Foster, THSCLLC
(Title)

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	170	Skilled (SNF)	170	62,050	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	170	TOTALS	170	62,050	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,596	13,549	5,761	51,906	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,596	13,549	5,761	51,906	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.65%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/12/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 170 and days of care provided 5,761

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marigold Health Care Center # 31245 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	249,802	17,438	9,021	276,261		276,261	(6,873)	269,388			1
2	Food Purchase		273,461		273,461		273,461	(707)	272,754			2
3	Housekeeping		12,192	141,729	153,921		153,921		153,921			3
4	Laundry		19,085	94,486	113,571		113,571		113,571			4
5	Heat and Other Utilities			155,274	155,274		155,274		155,274			5
6	Maintenance	50,457	23,804	81,059	155,320		155,320		155,320			6
7	Other (specify):* Trash Removal			10,438	10,438		10,438		10,438			7
8	**TOTAL General Services**	300,259	345,980	492,007	1,138,246		1,138,246	(7,580)	1,130,666			8
	B. Health Care and Programs											
9	Medical Director			15,057	15,057		15,057		15,057			9
10	Nursing and Medical Records	2,110,441	132,144	10,140	2,252,725		2,252,725		2,252,725			10
10a	Therapy		3,952	242,972	246,924		246,924		246,924			10a
11	Activities	106,936	711	6,137	113,784		113,784		113,784			11
12	Social Services	87,808	7	2,492	90,307		90,307		90,307			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,305,185	136,814	276,798	2,718,797		2,718,797		2,718,797			16
	C. General Administration											
17	Administrative	73,786			73,786		73,786		73,786			17
18	Directors Fees											18
19	Professional Services			484,957	484,957		484,957	4,178	489,135			19
20	Dues, Fees, Subscriptions & Promotions			87,278	87,278		87,278	(59,349)	27,929			20
21	Clerical & General Office Expenses	172,215	46,093	113,705	332,013		332,013	(91,121)	240,892			21
22	Employee Benefits & Payroll Taxes			501,982	501,982		501,982	12,599	514,581			22
23	Inservice Training & Education			4,558	4,558		4,558		4,558			23
24	Travel and Seminar			9,258	9,258		9,258	1,361	10,619			24
25	Other Admin. Staff Transportation			6,886	6,886		6,886		6,886			25
26	Insurance-Prop.Liab.Malpractice			180,278	180,278		180,278	7,408	187,686			26
27	Other (specify):*											27
28	**TOTAL General Administration**	246,001	46,093	1,388,902	1,680,996		1,680,996	(124,924)	1,556,072			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,851,445	528,887	2,157,707	5,538,039		5,538,039	(132,504)	5,405,535			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marigold Health Care Center #31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			284,139	284,139		284,139		284,139			30
31	Amortization of Pre-Op. & Org.			20,972	20,972		20,972	(20,971)	1			31
32	Interest			720,589	720,589		720,589	(1,355)	719,234			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,123	4,123		4,123		4,123			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,029,823	1,029,823		1,029,823	(22,326)	1,007,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,715	96,124	353,839		353,839		353,839			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		257,715	192,484	450,199		450,199		450,199			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,851,445	786,602	3,380,014	7,018,061		7,018,061	(154,830)	6,863,231			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,873)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,355)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(707)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,072)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,643)	21		24
25	Fund Raising, Advertising and Promotional	(59,349)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(16,955)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,954)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(20,971)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	26,095	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,124		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (154,830)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops		x	(3,845)		41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ (3,845)		47

STATE OF ILLINOIS

Marigold Health Care Center

ID# 31245

Report Period Beginning: 07/01/2004

Ending: 06/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (16,955)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,955)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marigold Health Care Center **#** 31245 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(6,873)	0	0	0	0	0	0	0	0	0	0	(6,873)	1
2	Food Purchase	(707)	0	0	0	0	0	0	0	0	0	0	(707)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,580)	0	0	0	0	0	0	0	0	0	0	(7,580)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,178	0	0	0	0	0	0	0	0	0	4,178	19
20	Fees, Subscriptions & Promotions	(59,349)	0	0	0	0	0	0	0	0	0	0	(59,349)	20
21	Clerical & General Office Expenses	(91,670)	549	0	0	0	0	0	0	0	0	0	(91,121)	21
22	Employee Benefits & Payroll Taxes	0	12,599	0	0	0	0	0	0	0	0	0	12,599	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,361	0	0	0	0	0	0	0	0	0	1,361	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,408	0	0	0	0	0	0	0	0	0	7,408	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(151,019)	26,095	0	0	0	0	0	0	0	0	0	(124,924)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(158,599)	26,095	0	0	0	0	0	0	0	0	0	(132,504)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Marigold Health Care Center** **#** **31245** **Report Period Beginning:** **07/01/2004** **Ending:** **06/30/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(20,971)	0	0	0	0	0	0	0	0	0	0	(20,971)	31
32	Interest	(1,355)	0	0	0	0	0	0	0	0	0	0	(1,355)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,326)	0	0	0	0	0	0	0	0	0	0	(22,326)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(180,925)	26,095	0	0	0	0	0	0	0	0	0	(154,830)	45

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		19	Professional Services	$	Mid America Care Foundation	100.00%	$ 4,178	$ 4,178	1
2	V		21	Clerical & Other		Mid America Care Foundation	100.00%	549	549	2
3	V		22	Employee Benefits		Mid America Care Foundation	100.00%	12,599	12,599	3
4	V		24	Travel & Seminar		Mid America Care Foundation	100.00%	1,361	1,361	4
5	V		26	Insurance		Mid America Care Foundation	100.00%	7,408	7,408	5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$ 26,095	$ * 26,095	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mid America Care Foundation
Street Address: 7611 State Line Rd Ste 301
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816-444-0900
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Patient Days	205,997	7	$ 16,582	$	51,906	$ 4,178	1
2	21	Clerical & Other	Patient Days	205,997	7	2,179		51,906	549	2
3	22	Employee Benefits	Patient Days	205,997	7	50,000		51,906	12,599	3
4	24	Travel & Seminar	Patient Days	205,997	7	5,402		51,906	1,361	4
5	26	Insurance	Patient Days	205,997	7	29,400		51,906	7,408	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 103,563	$		$ 26,095	25

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Wataga Class 5D Bonds		X	Mortgage	Varies		$ 6,700,000	$ 7,065,660	Various	Various	$ 720,589	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Income		X								(1,355)	6
7												7
8												8
9	TOTAL Facility Related						$ 6,700,000	$ 7,065,660			$ 719,234	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,700,000	$ 7,065,660			$ 719,234	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Marigold Health Care Center **#** 31245 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Health Care Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 31245

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,584 B. General Construction Type: Exterior Brick & Block Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 609,864
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 20,972
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	46,584		$ 150,000	1
2					2
3	TOTALS	46,584		$ 150,000	3

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		86	71	$ 4,371,070	$ 145,702	30	$ 145,702	$	$ 2,731,919	4
5	CIP				8,340						5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements 1986			1986	25,183	839	Various	839		15,739	9
10	Improvements 1987			1987	283,302	9,604	Various	9,604		173,662	10
11	Improvements 1988			1988	4,092		Various			4,092	11
12	Improvements 1990			1990	7,462		Various			7,462	12
13	Improvements 1991			1991	33,031	100	Various	100		32,910	13
14	Improvements 1992			1992	48,921		Various			48,921	14
15	Improvements 1993			1993	10,454	1	Various	1		10,443	15
16	Improvements 1994			1994	41,587	679	Various	679		41,587	16
17	Improvements 1995			1995	39,531	2,475	Various	2,475		39,170	17
18	Improvements 1996			1996	20,688	1,414	Various	1,414		13,825	18
19	Improvements 1997			1997	53,361	2,150	Various	2,150		24,102	19
20	Improvements 1999			1999	53,126	4,777	Various	4,777		28,921	20
21	Improvements 2001			2001	85,739	9,507	Various	9,507		37,611	21
22	Replaced sidewalk			2002	8,900	593	15	593		1,928	22
23	Water softners			2002	8,372	837	10	837		2,930	23
24	Water heater			2002	6,359	636	10	636		2,226	24
25	Door & Fram			2002	2,944	196	15	196		638	25
26	Architect fees			2002	89,388	2,980	30	2,980		9,187	26
27	Doors & Hardware			2002	13,400	893	15	893		2,754	27
28	Roof Repair			2002	140,929	14,093	10	14,093		45,802	28
29	Replace doors			2002	12,200	610	20	610		1,932	29
30	Shower room tile			2002	809	40	20	40		118	30
31	Replace kitchen door			2002	1,441	144	10	144		396	31
32	Add curb & pipe flashing			2002	705	70	10	70		182	32
33	Roof Repair			2002	9,628	963	10	963		2,487	33
34	Entrance, lobby, reception office wallcoverings			2002	9,120	1,824	5	1,824		4,560	34
35	Door jams & windows			2002	18,000	900	20	900		2,475	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Re-tile 6 showers	2002	$ 23,668	$ 1,183	20	$ 1,183	$	$ 3,452	37
38	Lobby/Admin flooring	2002	11,506	1,151	10	1,151		3,164	38
39	Outside storage building	2003	9,206	921	10	921		2,301	39
40	Concrete sidewalk	2003	2,430	162	15	162		297	40
41	Sprinkler work	2003	5,521	221	25	221		534	41
42	Assurance vinyl 63 baths	2003	14,552	1,455	10	1,455		3,395	42
43	Interior remodel	2003	414,775	16,591	25	16,591		37,330	43
44	Maglock Alzheimers unit	2003	889	89	10	89		163	44
45	Retainer for sprinkler work	2003	613	25	25	25		45	45
46	Fire taping emergency exit	2003	770	77	10	77		128	46
47	Facility sign	2004	3,285	274	10	274		274	47
48	Wallcovering	2004	1,106	221	5	221		313	48
49	Ceramic flooring	2004	1,185	59	20	59		84	49
50	Resident room signs	2004	688	138	5	138		172	50
51	Wood Door	2004	1,333	89	15	89		111	51
52	Instal handicap toilet	2004	1,770	88	20	88		125	52
53	Patient Room signs	2004	830	166	5	166		194	53
54	IPC door and wall protection	2004	4,212	281	15	281		304	54
55	Alheimer unit expansion	2004	183,374	9,169	20	9,169		11,461	55
56	Wanderguard system	2004	1,954	114	10	114		114	56
57	Sidewalk	2005	1,200	20	15	20		20	57
58	Front sidewalk	2005	2,900	48	15	48		48	58
59	Driveway for pathways unit	2005	8,995	600	5	600		600	59
60	Entrance door & frame	2005	3,269	91	15	91		91	60
61	Exterior door	2005	2,531	21	20	21		21	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,110,644	$ 235,281		$ 235,281	$	$ 3,352,720	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,137,070	$ 48,140	$ 48,140	$		$ 950,748	71
72	Current Year Purchases	50,627	718	718			718	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,187,697	$ 48,858	$ 48,858	$		$ 951,466	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,448,341	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 284,139	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 284,139	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,304,186	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 4,123 Description: See attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	1,351	$ 86,463	$	1,351	$ 86,463	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		231	15,509		231	15,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,203	141,000		2,203	141,000	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,785	$ 242,972	$	3,785	$ 242,972	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Marigold Health Care Center # 31245 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,787	$	1
2	Cash-Patient Deposits	23,600		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,304,055		3
4	Supply Inventory (priced at)	17,541		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,306		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,458,289	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	150,000		13
14	Buildings, at Historical Cost	6,045,195		14
15	Leasehold Improvements, at Historical Cost	65,449		15
16	Equipment, at Historical Cost	1,187,697		16
17	Accumulated Depreciation (book methods)	(4,304,186)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	609,864		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(385,555)		20
21	Restricted Funds	13,997		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,382,461	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,840,750	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 439,859	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,600		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,246		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,122		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,642,936		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	64,124		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,335,887	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,065,660		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,065,660	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,401,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (8,560,797)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,840,750	$	48

***(See instructions.)**

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,786,224)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,786,224)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(774,573)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (774,573)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (8,560,797)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,154,516	1
2	Discounts and Allowances for all Levels	(995,805)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,158,711	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	483,538	6
7	Oxygen	14,855	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 498,393	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,845	13
14	Non-Patient Meals	6,873	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	437,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,311	19
20	Radiology and X-Ray		20
21	Other Medical Services	82,119	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 568,074	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,355	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,355	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	16,955	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,955	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,243,488	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,138,246	31
32	Health Care	2,718,797	32
33	General Administration	1,680,996	33
	B. Capital Expense		
34	Ownership	1,029,823	34
	C. Ancillary Expense		
35	Special Cost Centers	353,839	35
36	Provider Participation Fee	96,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,018,061	40
41	**Income before Income Taxes (line 30 minus line 40)****	(774,573)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (774,573)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	13,464	14,643	$ 220,671	$ 15.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,940	10,840	206,928	19.09	3
4	Licensed Practical Nurses	37,737	41,007	588,367	14.35	4
5	CNAs & Orderlies	90,450	96,859	864,139	8.92	5
6	CNA Trainees	3,604	3,990	40,638	10.18	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,664	9,587	98,016	10.22	10
11	Social Service Workers	5,798	6,314	80,783	12.79	11
12	Dietician	28,762	30,466	232,179	7.62	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,200	4,601	46,789	10.17	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,816	2,040	73,786	36.17	20
21	Assistant Administrator					21
22	Other Administrative	9,382	10,445	115,043	11.01	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,181	2,401	33,953	14.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	215,998	233,193	$ 2,601,292 *	$ 11.16	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	94	$ 9,021	1,3	35
36	Medical Director	301	15,057	9,3	36
37	Medical Records Consultant	9	800	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	207	8,423	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,306	11,3	44
45	Social Service Consultant	32	2,083	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	687	$ 37,690		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jo Vann Azer	Administrator	0	$ 73,786
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,786

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Purchased Services	Various	$ 64,650
Management Fees	Various	374,581
Legal Fees	Various	17,406
Accounting Fees	Various	9,235
Data Processing Fees	Various	10,245
Professional Services	Various	840
Trustee Expenses	Various	8,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 484,957

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 186,926
Unemployment Compensation Insurance	
FICA Taxes	233,561
Employee Health Insurance	61,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	4,482
Qualified/Non qualified Pension	15,600
Home Office Allocation	
	12,599
TOTAL (agree to Schedule V, line 22, col.8)	$ 514,581

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,145
Health Care Worker Background Check	
(Indicate # of checks performed)	
Employment Expense	7,415
Advertising & Public Relations	59,349
Dues & Subscriptions	12,369
Less: Public Relations Expense	( )
Non-allowable advertising	(59,349)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,929

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,258
Seminar Expense	
Home Office Allocation	1,361
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,619

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marigold Health Care Center # 31245 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Marigold Health Care Center # 31245 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **$ 9,828 - Illinois Health Care Assoc**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,319** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,360**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,873**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD, LLP Kansas City** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **In Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.